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PRINTED: 02/22/2011 FORM APPROVED OMB NO. 0938-0391

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155769	B, WI	۱G		i i	C 17/2011
	ROVIDER OR SUPPLIER	CAMPUS	•	41	EET ADDRESS, CITY, STATE, ZIP CODE 00 N MORRISON ROAD UNCIE, IN 47304	•	
(X4) ID PŘEFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F	000			
" January Paris, " January " " " " " " " " " " " " " " " " " " "	This visit was for a Licensure Survey. Investigation of Cor Complaint IN00085 Federal/State defici allegations are cited F9999. Survey dates: Febru Facility number: 01: Provider number: 1: AIM number: N/A Survey team: Betty Retherford, R Ginger McNamee, I Karen Lewis, RN Census Bed Type: SNF: 56 Residential: 29 Total: 85 Census Payor Type Medicare: 32 Other: 53 Total: 85 Sample: 14 Residential Sample These deficiencies cited in accordance	Recertification and State This visit included the mplaint IN00085707. 707-Substantiated, lencies related to the d at F279, F323, F514 and uary 14, 15, 16, and 17, 2011 1596 55769 N, TC RN RECEIVED MAR 1 0 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HE : 7 also reflect State findings			Preparation or execution this plan of correction of not constitute admission agreement of provider of truth of the facts allege conclusions set forth of the statement of Deficienci. The plan of corrections prepared and executed because it is required because it is plan correction as the provide credible allegation of compliance. The Provider respectfull requests a desk review paper compliance to be considered in establishing that the provider is in substantial compliance.	does on or of the d or n the es. is solely y the State spond uring ual 2011. of ler's	
1,0	Bev Faulkner, RN	•					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	ع	xecuteur Director	, 3,	(X6) DAJTE 8 1

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155769	B. WING_	·····	1	C 7/2011	
	PROVIDER OR SUPPLIER ON WOODS HEALTH	CAMPUS	4	REET ADDRESS, CITY, STATE, ZIP CODE 1100 N MORRISON ROAD MUNCIE, IN 47304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 278	483.20(g) - (j) ASSI ACCURACY/COOF The assessment m resident's status. A registered nurse each assessment w participation of heat A registered nurse assessment is come Each individual who assessment must stat portion of the attempt of the auxilifully and knowing false statement in a subject to a civil most \$1,000 for each assignification willfully and knowing to certify a material resident assessment penalty of not more	ESSMENT RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate vith the appropriate ith professionals. must sign and certify that the pleted. completes a portion of the ign and certify the accuracy of	F 278	DEFICIENCY)	shed for e been ent RD of curately fall since 2010. RD of urately resident najor ent on		
	assessment. Clinical disagreement does not constitute a material and false statement.			1/30/2011 was corrected to accreflect the number of falls the had with no injury, injury or minjury since the prior assessment 11/13/10	resident najor		
	by: Based on record re failed to ensure Mir were completed act falls for 3 of 11 resi	view and interview, the facility simum Data Set Assessments curately in regards to resident dents reviewed for accuracy of Assessments in a sample of t, C, and F)		11/13/10.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLETED	
		155769	B. WIN	1G		3	7/2011
	PROVIDER OR SUPPLIER ON WOODS HEALTH	i CAMPUS		41	EET ADDRESS, CITY, STATE, ZIP CODE 100 N MORRISON ROAD IUNCIE, IN 47304		
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F 278	Continued From pa	age 2	F	278			
	2/14/11 at 1:00 p.m included, but were dementia without be dysfunction, diabet. The resident had a Data Set [MDS] as indicated the reside assessment on 11. Review of the "Fall And Intervention" for the resident had fawith no injury. During an interview 2/16/11 at 1:03 p.m aware of the MDS correctly for falls. 2. Resident #C's of 2/16/11 at 1:25 p.m included, but were compression fracture, and spinal Resident #C had a Data Set [MDS] as indicated the residual 10/8/10, admission the section of the anumber of falls wit injury were all code	tes mellitus type II. a 1/20/11, quarterly Minimum issessment. The assessment ent had no falls since the prior /5/10. I Circumstance, Assessment form, dated 12/29/10, indicated allen at 7:45 a.m., on that date with the Corporate Nurse on in., she indicated she was assessments not being coded clinical record was reviewed on in. The resident's diagnoses not limited to, vertebral ure, osteoporosis, pelvical stenosis. a 12/20/10, quarterly Minimum issessment. The assessment ent had fallen since the prior in assessment related to the hino injury, injury, and major			Identification of other reside having the potential to be af the same alleged deficient prand corrective actions taken. Clinical Care Coordinators withe most recent MDS of reside falls for past 30 days to ensure accurate coding of falls and fainjury since the prior assessment. Any MDS found to be coded inaccurately will be corrected Clinical Care Coordinators.	ractice :: ill review ents with e the all related ent.	

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F 278	And Intervention" for had fallen four time assessments and hoccurring on 11/18. During an interview 2/16/11 at 1:03 p.m aware of the MDS correctly for falls. 3. Resident #F's c 2/16/11 at 2:00 p.m included, but were hypertension, and disorder. The resident had a Data Set [MDS] as indicated the resident 1/13/10 quarterly in the section of the number of falls with injury were all code. Review of the "Fall And Intervention" for had fallen three time assessments. Two and one fall occurring the section of fall occurring the section of the section of the massessments. Two and one fall occurring the section of fall occurring the section of the section of the section of the massessments. Two and one fall occurring the section of the se	porms indicated Resident #C as during the period between and injury with two of the falls /10 and 11/27/10. With the Corporate Nurse on a sessessments not being coded linical record was reviewed on a The resident's diagnoses not limited to, osteoarthritis, seizure verses dystonic 1/30/11, quarterly Minimum sessment. The assessment ent had fallen since the prior MDS assessment related to the no injury, injury, and major	F 278		ucate the on section J the RAI the recurrence will be lieged to recurrence ted injury by corrected. If be surance asis until the recurrence will be surance are will be surance asis until the recurrence will be surance wil	
	During an interview 2/16/11 at 1:03 p.π	wwith the Corporate Nurse on n., she indicated she was assessments not being coded		guidelines. Date: March 19, 2011		
F 279	3.1-31(i) 483.20(d), 483.20(k)(1) DEVELOP	F 27	9		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279 SS=D	COMPREHENSIVE A facility must use t	E CARE PLANS he results of the assessment and revise the resident's	F2	279			
	The facility must de plan for each reside objectives and time medical, nursing, an needs that are identassessment.	velop a comprehensive care ent that includes measurable tables to meet a resident's and mental and psychosocial tified in the comprehensive describe the services that are			F 279 Corrective actions accomplish those residents found to have affected by the alleged deficie practice:	been	
	to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under § due to the resident's	ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment			Resident B was discharged 1/28 Resident D plan of care was up include refusal of meds / eye drainterventions were listed to include encourage the resident to accept medications and the potential pto be monitored related to her reaccept her medications.	dated to rops and lude of her roblems	
	by: Based on record reviabled to ensure a cowas developed for 3 development of com	IT is not met as evidenced view and interview, the facility emprehensive plan of care of 14 residents reviewed for apprehensive care plans in a ident #'s B, D, and E)			Resident E plan of care was up- include compression fracture are interventions were listed from to care instructions provided to the by the hospital.	nd he home	
	reviewed on 2/14/11 Diagnoses for Resid	ord for Resident #B was at 1:00 p.m. dent #B included, but was not r's disease, diabetes mellitus.					

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		155769	B. WING _		02/1	7/2011
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F 279	Continued From pa and vascular deme	·	F 279			
	Resident B's little to her left foot. The n was contacted and resident to see the	y, dated 10/7/10, indicated benail was loose and sore on ote indicated the physician a request was made for the podiatrist. ted 10/20/10, indicated		Identification of other resider having the potential to be affethe same alleged deficient prand corrective actions taken: Clinical Care Coordinators will Medication Administration Rec	ected by actice	
	that date. The form thickened toenails crumbly. The form incurved nail borde The form indicated	een seen by the podiatrist on indicated the resident had which were yellow and indicated the toenails had rs and painful nail borders. podiatry care was given. A		past 30 days to identify resident medication refusal. Will then e care plan is in place for medical refusal.	t ensure a tion	
	was seen again on concerns. Both for applied to the feet a	d 1/5/11, indicated the resident that date for the same ms indicated lotion should be after every shower.		Clinical Care Coordinators will 24 hour reports for past 30 days identify resident with diagnosis fracture. Will then ensure a car in place for the fracture.	s to of	
	health care plan ha the resident being	ving been developed related to a diabetic with a history of a roblems with her toenails		Clinical Care Coordinators will last podiatry notes on each residentify residents with toenail prequiring podiatry intervention.	dent to roblems	
	on 2/15/11 at 3:00 was requested rela comprehensive hea	with the Director of Nursing p.m., additional information ted to the lack of any alth care plan having been dent #B's toenail and podiatry		then ensure a care plan is in pla toenail concerns.	ce for the	
	Director of Nursing	on 2/16/11 at 10:00 a.m., the gindicated she was unable to ehensive health care plan for atry concerns.				:
	2.) Resident #D's	clinical record was reviewed on				

NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS CA(1) D		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		(X3) DATE SU COMPLE	
MORRISON WOODS HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION BIOLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279			155769				
F 279 Continued From page 6 2/14/11 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, osteoporosis, dementia, and glaucoma. The January 2011 Medication Administration Record (MAR) indicated Resident #D refused medications and/or eye drops almost daily. The MAR indicated the resident had orders for two eye drops for Glaucoma. The MAR indicated the resident had orders for seven oral medications. The MAR indicated the resident had orders for seven oral medications. The clinical record lacked any comprehensive health care plan related to the resident refusing her medications and/or eye drops, approaches to be used to encourage the resident to accept her medications. During an interview with the Administrator and Director of Nursing on 2/15/11 at 3:00 p.m., additional information was requiseted regarding.		•	<u></u>	4	100 N MORRISON ROAD	<i>O2,</i> 13	72011
2/14/11 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, osteoporosis, dementia, and glaucoma. The January 2011 Medication Administration Record (MAR) indicated Resident #D refused medications and/or eye drops almost daily. The MAR indicated the resident had orders for two eye drops for Glaucoma. The MAR indicated the resident refused a total of 41 doses of the eye drop medications during the month on January. The MAR indicated the resident had refused a total of 149 doses of the oral medications. The clinical record lacked any comprehensive health care plan related to the resident refusing her medications and/or eye drops, approaches to be used to encourage the resident to accept her medications, and/or potential problems to be monitored related to her refusal to accept her medications. During an interview with the Administrator and Director of Nursing on 2/15/11 at 3:00 p.m., additional information was requested regarding.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI	JLD BE	COMPLETION
the lack of health care planning for Resident #D's refusal to take her medications and or eye drops. During an interview on 2/16/11 at 10:00 a.m., the Director of Nursing indicated she was unable to provide any health care planning related to Resident #D's refusing medications and/or eye drops. 3.) Resident #E's clinical record was reviewed on 2/15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to falls and	F 279	2/14/11 at 11:30 a. included, but were disease, osteoporo The January 2011 Record (MAR) indimedications and/or MAR indicated the eye drops for Glauresident refused a drop medications of The MAR indicated seven oral medications. The clinical record health care plan reher medications and be used to encoura medications, and/or monitored related to medications. During an interview Director of Nursing additional informational the lack of health care plan refusal to take her During an interview Director of Nursing additional informational the lack of health carefusal to take her During an interview Director of Nursing provide any health Resident #D's refudops. 3.) Resident #E's 62/15/11 at 12:30 p.	m. The resident's diagnoses not limited to, Parkinson's sis, dementia, and glaucoma. Medication Administration cated Resident #D refused eye drops almost daily. The resident had orders for two coma. The MAR indicated the total of 41 doses of the eye during the month on January. If the resident had orders for ions. The MAR indicated the ed a total of 149 doses of the elected at the resident refusing addor eye drops, approaches to age the resident to accept her repotential problems to be on her refusal to accept her with the Administrator and on 2/15/11 at 3:00 p.m., for was requested regarding are planning for Resident #D's medications and or eye drops. You can be a sumable to care planning related to sing medications and/or eye clinical record was reviewed on m. The resident's diagnoses	F 279	Measures put into place and sechanges made to ensure the aldeficient practice does not recomply of the corrective measure of the comprehensive does not recomprehensive careplan is in prelated to resident with fracture problems that required podiatry intervention and medication reformation of the comprehensive of the condition of the con	e the uideline an vill be ed cur: are plans re a lace es, toenail fusal.	

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F 279	Continued From pa	age 7	F 279	1.100.00		
		1, "Fall Circumstance, stervention" indicated the a.m. on 1/25/11.				
	Department Discharesident had a combones in his spine. included, but were sitting; during the fan ice pack for 20 hours to reduce swahower, hot bath o	1, 4:37 a.m., "Emergency arge Instructions" indicated the apression fracture of one of the Some home care instructions not limited to: avoid prolonged first two days after injury apply minutes every two to four relling and pain; heat (hot r heating pad) works well for art with ice, then switch to heat				
	Review of the residerence to the co	lent's plan of care lacked any mpression fracture.				
	and the Corporate they indicated there	with the Director of Nursing R.N. on 2/16/11 at 1:03 p.m., e was no information related to pression fracture in the are.				·
	dated 1/08, provide p.m., titled "INTER PLAN GUIDELINE to, the following: "PURPOSE: To er services and comm resident's needs, s impairment, disabil with state and fede PROCEDURE:	rent revised facility policy, ed by DoN on 2/16/11 at 12:58 DISCIPLINARY TEAM CARE ", included, but was not limited insure appropriateness of nunication that will meet the everity/stability of conditions, lity, or disease in accordance eral guidelines. ensive care plan should be mange in condition updates with				

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDIN	G	COMPLETED	
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F 279	each MDS assessn h. The care plan revised as needed	nent should be reviewed and with each MDS assessment reas should be printed and g care plans"	F	279			
F 323 SS=G	3.1-35(b)(2) 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on record refailed to ensure a refalls had a safety all physician for 1 of 6 reviewed for application prevent falls resulting the emergency roof	sure that the resident has as free of accident hazards each resident receives on and assistance devices to a view and interview, the facility esident identified at risk for arm on as ordered by the residents in a sample of 14 ation of interventions to no in a fall requiring transfer to	F	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4100 N MORRISON ROAD MUNCIE, IN 47304	ODE		
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F 323	1.) The clinical recreviewed on 2/14/1 Diagnoses for Resi limited to, Alzheime and vascular deme A Quarterly Minimu (MDS), dated 1/20/problems understar understood by othe resident had poor drequired cueing and indicated the resident the staff for all trans. A health care plan processed to a history of from an antipsychotic ause. One of the apport the staff to utilize ordered. A current physician indicated "bed and check placement and the complete and check placement and complete and complete and complete assistant-complete assistant-complete assistant-complete and complete assistant-complete assistant-complete assistant-complete assistant-complete and complete and complet	ord for Resident #B was 1 at 1:00 p.m. dent #B included, but was not en's disease, diabetes mellitus, intia with behaviors. m Data Set assessment 11, indicated Resident #B had anding others and of being insected the decision making ability and disupervision. The MDS entirequired the assistance of effers and toileting. Droblem, last reviewed on Resident #B was at risk for falls alls, Alzheimer's dementia, and antidepressant medication proaches for this problem was eighed and chair alarms as 's order, dated 1/4/11, chair alarm on at all times, and & function every shift." ded 1/26/11 at 3:35 p.m., or limited to, the following: a on 200 hall by TSA [Trilogy proporation name for a CNA]. Side on the floor. Lacerations entusion to mid forehead MD we order to send to ER for eval [evaluation] and tx [complains of] pain all over, nead." The nursing note	F 32	Corrective actions accompthose residents found to ha affected by the alleged defipractice: Resident B was discharged 1/28/2011. Resident C fall circumstance 11/19/2010 – the section for Inspection which asks the quafety equipment is in place fucntioning at the time of the was corrected. Identification of other residential to be a the same alleged deficient and corrective actions take Clinical Care Coordinators wall residents with alarms to ealarms are in place and functional plan is in place and alarms at the C.N.A. Assignment sheet	ave been icient on e form dated or Equipment uestion if and e incident dents affected by practice en: will review ensure tioning, care are listed on		
	lacked any informa	tion relating to the residents					

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F 323	personal alarm have fall. A nursing note, data included, but was represented the returned vertebrae 3] fx [fractive fraction of the fall	ring sounded at the time of the red 1/26/11 at 9:10 p.m., not limited to, the following: to facility. Has a C3 [cervical cture]. To have collar on at all dent give an (sic) Hydrocodone pain medication] at 2030 [8:30 red 1/26/11, included, but was ollowing: The rest following a fall. The red arrival. The occurrence de. Fell face forward out of location where the incident nursing home Very large hematoma sion	F	Di sta Gu He de Di res en:	deasures put into place and system anges made to ensure the allesticient practice does not recurs. HS or designee will re-educate accurate completion of the fall reumstance assessment form. HS or designee will re-educate aff on the Falls Management Providedines. The corrective measure will only the corrective measure will only the alleged ficient practice does not recurs. HS or designee will observe 5 didents per week times 60 days sure personal alarms are in place anctioning per resident plan of careful to the corrective measure in place anctioning per resident plan of careful to the corrective measure in place anctioning per resident plan of careful to the corrective measure in place anctioning per resident plan of careful to the corrective measure in place and the corrective measure will be corrected as a correct measure will be corrected as a correct measure will be corrected as a correct measure will be corrected as a corrected as a correct measure will be corrected as a correct measure will be corrected as a corrected as	eged r: nurses l nursing ogram ll be r: to ce and	

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	PROVIDER OR SUPPLIER	CAMPUS		4100	T ADDRESS, CITY, STATE, ZIP CODE ON MORRISON ROAD NCIE, IN 47304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRËFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	patient to follow up physician]." A "Fall Circumstant Intervention" form, resident had been fhall living area on 1 indicated the reside forehead, nose, and form contained a se inspection" which reand functioning at tiplace to circle eithe circled. During an interview on 2/15/11 at 12:30 was requested related 1/26/11. An "Episodic Event Administrator on 2/1 completed on 2/1/1 limited to, the follow "Event What occurred? Res [resident] was two [wheelchair] on living area next to the She had large hemal laceration to nose, a Complained of head NOT witnessed. Reson her w/c as per hereal completed on per hereal completed on per hereal completed.	with [name of orthopedic be Assessment and dated 1/27/11, indicated the ound on the floor in the 200 /26/11 at 3:35 p.m. The forment sustained injuries on her did top lip and had a C3 fx. The fection for "Equipment ead "Safety equipment in place ime of incident?" There was a right yes or no. No answer was with the Director of Nursing p.m., additional information fed to Resident #B's fall on Form", provided by the 15/11 at 1:50 p.m., dated as 1, included, but was not fring: found lying on floor in front of 1/26/11 at 3:35 p.m. in the ne 200 hall nurses station. In a state of the property of the state of the property of the state of the property o	F3		The results of the audits will be presented to the Quality Assura Committee on a monthly basis consistent applications of guide noted. Periodic evaluation will conducted for following applications. Date: March 19, 2011	unce until lines are be		

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/22/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	G	COMPLETED	
		155769	B. WII	√G		ł .	C 7/2011
	ROVIDER OR SUPPLIER ON WOODS HEALTH	CAMPUS		41	REET ADDRESS, CITY, STATE, ZIP CODE 100 N MORRISON ROAD IUNCIE, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323 F 514 SS=B	During an interview Administrator indica alarm had not been of the resident's fall 2.) Review of a curdated 3/08, provide p.m., titled "FALLS GUIDELINES", inclithe following: "PURPOSE: Trilogy health Servia hazard free envirofactors and implem PROCEDURE: 1. The fall risk as of the Admission ar Assessment and Reforms: b. Care plan interimplemented that a factors" This federal tag relation for the facility must mare sident in accorda standards and practaccurately docume systematically organized.	on 2/15/11 at 1:50 p.m., the ated the resident's personal on and functioning at the time on 1/26/11 at 3:35 p.m. Trent revised facility policy d by DoN on 2/16/11 at 1:00 MANAGEMENT PROGRAM uded, but was not limited to, ces (THS) strives to maintain onment, mitigate fall risk ent preventative measures sessment is included as part and Monthly Nursing eview and Circumstance rventions should be ddress the residents's risk ates to complaint LETE/ACCURATE/ACCESSIB aintain clinical records on each noce with accepted professional circes that are complete; nted; readily accessible; and		514			
		must contain sufficient ify the resident; a record of the					

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CLIVIL	VO LOLL MEDIOVIVE	A MEDICAID SERVICES				ONID NO.	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		155769	B. WII	۷G		i	C 7/2011
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1	
					100 N MORRISON ROAD		
MORRIS	ON WOODS HEALTH	CAMPUS		М	UNCIE, IN 47304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	·	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	- 1	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ÚLD BE	COMPLETION DATE
	<u> </u>			<u> </u>	F 514		
F 514	, ,			514			
		ents; the plan of care and			Corrective actions accompli		
	services provided; the results of any preadmission screening conducted by the State;				those residents found to have been		
	and progress notes				affected by the alleged deficient		
	This REQUIREMENT is not met as evidenced by:				practice:		
					Resident B was discharged or	n	
					1/28/2011.	•	
		eview and interview, the facility					
	l .	ident clinical records were			Resident C fall circumstance	form dated	
	complete and accurately documented for 2 of 6 residents reviewed for completion and accuracy of fall circumstance forms in a sample of 14. (Resident #B and #C)				11/19/2010 – the section for 1	Equipment	
					Inspection which asks the que	estion if	
					safety equipment is in place a	ınd	
					functioning at the time of the	incident .	
	Findings include:	ings include:			was corrected.		
-	A) The effective a	and for Danidant #D was			Identification of other resid	ents	
	reviewed on 2/14/1	ord for Resident #B was			having the potential to be at		
•	Teviewed on 211+11	1 at 1.00 p.m.			the same alleged deficient p	•	
	A current physician	's order, dated 1/4/11,			and corrective actions taken		
		chair alarm on at all times,					
	check placement a	nd & function every shift."			DHS or designee will review	the fall	
	A	- 14/00/44 -4-0-05			circumstance forms for the pa		
		ed 1/26/11 at 3:35 p.m., ot limited to, the following:			to ensure the forms are comp		
		ea on 200 hall by TSA [Trilogy			accurate.		
		orporation name for a CNA].					
	l	Resident found on side on the floor The nursing note lacked any information relating to the			Measures put into place and	l systemic	
					changes made to ensure the	alleged	
	residents personal alarm having sounded at the				deficient practice does not r	ecur:	
	time of the fall.						
:	A "Fall Circumstand	ca Accessment and			DHS or designee will re-educ		
		dated 1/27/11, indicated the			on accurate completion of the		:
		found on the floor in the 200			circumstance assessment form	n.	
		/26/11 at 3:35 p.m. The form					
		for "Equipment inspection"			DHS or designee will re-educ	-	3
		equipment in place and			staff on the Falls Managemer	t Program	

Guidelines.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 02/17/2011 155769 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4100 N MORRISON ROAD MORRISON WOODS HEALTH CAMPUS **MUNCIE, IN 47304** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 14 functioning at time of incident?" There was a place to circle either yes or no. No answer was circled. During an interview on 2/15/11 at 1:50 p.m., the Administrator indicated the resident's personal How the corrective measure will be alarm had not been on and functioning at the time monitored to ensure the alleged of the resident's fall on 1/26/11 at 3:35 p.m. deficient practice does not recur: 2.) The clinical record for Resident #C was DHS or designee will review fall reviewed on 2/16/11 at 1:25 p.m. circumstance forms after they are initiated to ensure they are complete and A recapitulation of physician's orders, dated accurate times 60 days. 12/1/10, indicated Resident #C had orders for bed and chair alarms due to confusion. The original date of these orders was 10/1/10. The results of the audits will be presented to the Quality Assurance A "Fall Circumstance Assessment and Committee on a monthly basis until Intervention" form, dated 11/19/10, indicated consistent applications of guidelines are Resident #C had fallen on 11/18/10 at 9:45 p.m. noted. Periodic evaluation will be The form contained a section for "Equipment conducted for following applicable inspection" which read "Safety equipment in place guidelines. and functioning at time of incident?" The answer "yes" was circled on the form. Date: March 19, 2011 During an interview with the Director of Nursing on 2/16/11 at 3:35 p.m., additional information was requested regarding Resident #C's fall on 11/18/10 at 9:45 p.m. A fall investigation form, provided by the Administrator on 2/17/11 at 10:00 a.m., related to the 11/18/10 fall indicated the alarm had not been working at the time of the fall. The form indicated the batteries were dead and the alarm had not sounded.

This federal tag relates to complaint

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUII	LDING			С		
		155769	B. WIN	G_			7/2011		
	NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON ROAD MUNCIE, IN 47304					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 514	Continued From pa #IN00085707. 3.1-50(a)(1)	ige 15	F 5	514					
F9999	3.1-50(a)(2) FINAL OBSERVAT	TONS	F99	999	•				
	State Findings:	NATION AND MANAGEMENT							
	(g)(1) The administ overall management function as a depart example, director of supervisor, during the responsibilities of the but are not limited to the telephone, followed twenty-four (24) how that directly threated of the resident or relimited to, any: (A) epidemic outbre (B) poisonings; (C) fires; or (D) major accidents of the department of the department of the division. This state rule was based on clinical residents.	trator is responsible for the nt of the facility but shall not trental supervisor, for of nursing or food service the same hours. The ne administrator shall include, to, the following: forming the division by the sy written notice within urs, of unusual occurrences on the welfare, safety or health esidents, including, but not eaks; s. annot be reached, such as on ads, a call shall be made to the one number ((317) 383-6144) not met as evidenced by:							
	facility failed to ensing Department of Hea	ecord review and interview, the sure the Indiana State sith was notified in a timely ent's death occurring 2 days			·				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		155769	B. WIN	IG		02/17	C 7/2011
	ROVIDER OR SUPPLIER ON WOODS HEALTH	CAMPUS		4	REET ADDRESS, CITY, STATE, ZIP CODE 100 N MORRISON ROAD TUNCIE, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) . COMPLETION DATE
F9999	reviewed who expir sample of 14. (Res Findings include: 1.) The clinical rec reviewed on 2/14/1 Diagnoses for Resi limited to, Alzheime and vascular deme. A current physician indicated "bed and check placement a. A nursing note, data included, but was not expire assistant-or Resident found on to nose and lip. Complete [medical doctor] gas [emergency room]: [treatment] C/O but generalized in heacked any information personal alarm have fall. A nursing note data included, but was not expire the same same personal alarm have fall. A nursing note data included, but was not expire the same same same same same same same sam	injuries for 1 of 1 resident ed 2 days following a fall in a sident #B) ord for Resident #B was 1 at 1:00 p.m. dent #B included, but was not er's disease, diabetes mellitus,	F99	999	State Finding: F9999 Corrective actions accomplished for those residents found to have affected by the alleged deficient practice: No other residents were affected by this alleged de practice. The campus Exe Director or designee will r the Long Term Care Divis the Indiana State Departn Health within 24 hours of major accident or an unus death per the facility polici entitled "Abuse and Negle Procedural Guidelines" ar accordance with Indiana S guidelines for reporting.	eficient ecutive notify ion of nent of a sual y	

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(X3) DATE SURVEY

MORRISON WOODS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFIN (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING III F9999 Continued From page 17 An ED [emergency department] progress note, dated 1/26/11, incl	DIENCIES I PRI PRORMATION) TO	STRE	EET ADDRESS, CITY, STATE, ZIP CODE 10 N MORRISON ROAD JNCIE, IN 47304 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHICROSS-REFERENCED TO THE APP	C 02/17/2011
MORRISON WOODS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFIN (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING III F9999 Continued From page 17 An ED [emergency department] progress note, dated 1/26/11, incl	CIENCIES I DED BY FULL PRI NFORMATION) TA	STRE 410 ML	EET ADDRESS, CITY, STATE, ZIP CODE 100 N MORRISON ROAD JNCIE, IN 47304 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APF	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICE REGULATORY OR LSC IDENTIFYING II F9999 Continued From page 17 An ED [emergency department] progress note, dated 1/26/11, incl	DED BY FULL PRI	410 MU ID EFIX	OO N MORRISON ROAD JNCIE, IN 47304 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHICKOSS-REFERENCED TO THE APP	CTION (X5)
F9999 Continued From page 17 An ED [emergency department] progress note, dated 1/26/11, incl	DED BY FULL PRI	EFIX	(EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE APP	CTION (X5)
An ED [emergency department] progress note, dated 1/26/11, incl	F		DEFICIENCY)	OULD BE COMPLETION
"The patient presents following onset was just prior to arrival. The was a single episode. Fell face for wheelchair. The location where the occurred was at a nursing home Skin symptoms: Very large her forehead with abrasion Diagnosis Closed fracture of the cervical very large plan Condition: Stable Patient was given the following extended and the patient was a C3 fracture. To heall times. Nursing home to make patient to follow up with [name of physicial days. In the patient was given the follow up with [name of physicial days.]" During an interview with the Director on 2/15/11 at 12:30 p.m., addition was requested related to Resider 1/26/11. An "Episodic Event Form", provid Administrator on 2/15/11 at 1:50 completed on 2/1/11, included, but-	a fall. The e occurrence orward out of ne incident natoma tebra ducational an] within 1-2 cian] within 1-2 ave collar on at appointment for orthopedic ctor of Nursing al information at #B's fall on ed by the o.m., dated as	-9999 Fac	Identification of other residents having the pot to be affected by the sar alleged deficient practic corrective actions taken. All residents of the Health Center have the same pot to be affected by the same alleged deficient practice. incidents/accidents will be reviewed daily by the DHS the Executive Director to determine if the extent of injury would constitute a raccident. All deaths will be evaluated in light of recenevents and a determination made as to whether they the guidelines for reporting under the facility "Abuse a Neglect Procedural Guide Measures put into place systemic changes made ensure the alleged deficiency ractice does not recur: In-service education/traini was presented March 12, to campus employees in a departments. Subject maincluded "Abuse and Neglerocedural Guidelines" identifying and reporting procedures. Leaderships was in serviced March 10 on the process of reportinimmediately to the Execut Director any major accide incidents resulting in residingly as well as a residentifying and reporting as well as a residentifying as well as a residentifying and reporting as well as a residentifying and residentifying and residentifying and residentifying and reporting as well as a residentifying and residentify	ne e and : care tential e All e S and the major e to meet g and elines". and to ient g 2011, all tter lect staff , 2011 g tive nts lent

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155769	B. WI	1G		02/	C 17/2011
	PROVIDER OR SUPPLIER ON WOODS HEALTH	CAMPUS	!	410	ET ADDRESS, CITY, STATE, ZIP CODE 00 N MORRISON ROAD JNCIE, IN 47304	1 021	1//2011
(X4) ID PREFIX TAG			ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	limited to, the follow "Event What occurred? Res [resident] was w/c [wheelchair] on living area next to the She had large hemiliaceration to nose, and Complained of head NOT witnessed. Reson her w/c as per hivia 911. Diagnosis passed away on 1/2 During an interview Administrator indicate and the resider did not appear to make the she indicated she is death on 1/28/11 or 1/26/11 until after the contract of the she indicated the she	found lying on floor in front of 1/26/11 at 3:35 p.m. in the ne 200 hall nurses station. atoma above right eye, and abrasion to lip. d and nose pain. Fall was es did not have personal alarmer CP [care plan]. Sent to ER of C3 fracture. Resident 28/11 at 8:10 p.m" on 2/15/11 at 2:15 p.m., the sted she had not initially nt's fall on 1/26/11 because it eet the criteria for reporting. till did not report the resident's courring 2 days after the fall on the coroner visited the facility cated the coroner requested Resident #B and it was at that d to make the report to the thment of Health (ISDH). If Incident Report", dated the report was faxed to ISDH on This indicated a time period that resident expired in the ual occurrence was faxed to	F99	999	How the corrective measure will be monitored to ensure the alleged deficient practices does not recur: The Executive Director, Director of Health Services, or design will review and sign all accident/incidents within 24 hours of occurrence to determine the extent of injure Five (5) reports will be audited weekly for the next 4 weeks and monthly X 3 months with results forwarded to the Quanta Assessment and Assurance Committee for review. Completion Date: March 19, 2011	re ice ector nee y. ed s	
	This federal tag rela #IN00085707.	tes to complaint					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU		IG	COMPLETED	
		155769	B. WII	1G _		i i	C 7/2011
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS				4	REET ADDRESS, CITY, STATE, ZIP CODE 1100 N MORRISON ROAD MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		IOULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 19	F99	999			

anning and an analysis of the commence of the